

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH  
MANAGEMENT INFORMATION SYSTEM

CONFIDENTIALITY OATH FOR PASSWORD RECIPIENTS  
(Contract Providers)

I certify that I have read and received a copy of the Department of Mental Health Policy on Management Information System Confidentiality. I hereby agree to abide by all policies and procedures on confidentiality and instructions in the MIS Procedures Manual. I understand that disciplinary action up to and including termination from County employment may be invoked for violation of these policies and/or procedures.

Further, I understand that I may be liable for civil penalties under W and I Code Section 5328.

Signed \_\_\_\_\_

Facility/Office \_\_\_\_\_

Bureau \_\_\_\_\_

Date \_\_\_\_\_